



BASIC GROUP CRITICAL ILLNESS INSURANCE ENROLMENT REQUEST FORM

For Office Use Only
[]

1 Policy Information

| | | | |
|-------------------------|-----|---------------------|-----|
| Group Policyholder Name | [] | Group Policy Number | [] |
| Division Name | [] | Division Number | [] |

2 Employee Information

| | | | | | |
|--------------------|--|---------------|-----|---------------------------|--|
| Last Name | [] | Given Name | [] | Initials | [] |
| Gender | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth | [] | Province of Residence | [] |
| Date of Employment | [] | Occupation | [] | Employment Classification | <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other [] |

3 Amount of Insurance

| | | | |
|---------------------|-----|---------------------------------------|---|
| Amount of Insurance | [] | Waive the Eligibility Waiting Period: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Comments | [] | | |

4 Completed By

Note: Enrolment Forms must be completed and received by Industrial Alliance Pacific Insurance & Financial Services Inc. within 31 days of eligibility date to avoid the necessity of providing evidence of insurability.

| | | | |
|----------------------------|-----|------|-----|
| Benefit Administrator Name | [] | Date | [] |
|----------------------------|-----|------|-----|

5 Please mail or fax the Enrolment Request Form to:

Industrial Alliance Pacific Insurance and Financial Services Inc.
Attention: Special Markets Group
Mail: 2165 Broadway West
PO Box 5900
Vancouver BC V6B 5H6
Toll Free Fax: 1-888-553-5433